Section V

Preparation and Use of Other Inpatient Treatment Record Forms

9–20. DD Form 2569

Insurance information obtained on DD Form 2569 will be filed in the OTR and the ITR according to figures 6–1, 6–2, and 9–1. The original signed DD Form 2569 will be filed in the medical record applicable to the type of care, and a copy will be filed in the other type of medical record. For example, if the information is obtained during an inpatient visit, file the original in the ITR and a copy in the OTR. File one copy in the HREC and forward one copy to the billing office.

9–21. DD Form 2770

a. DD Form 2770 (Abbreviated Medical Record) (formerly SF 539) is used for cases of a minor nature that require no more than 48 hours' hospitalization. For example, it is used for lacerations, plaster casts, removal of superficial growths, and accident cases held for observation. It is also used for APV cases. DD Form 2770 will not be used for death cases, admission by transfer, probable medical-board cases, and cases involving serious medical conditions.

b. DD Form 2770 may also be used when military members are hospitalized for uncomplicated conditions not normally requiring hospitalization in the civilian sector; for example, measles or upper respiratory infection. If the case becomes complicated, *d*, below, applies.

c. DD Form 2770 may be used for cases in which general anesthesia was given only if—

(1) The patient is classified as American Society of Anesthesiologists Class I or II; that is, the patient has no organic, physiologic, biochemical, or psychiatric disturbance, or the systemic disturbance is well controlled, or the pathologic process to be operated on is localized and does not entail a systemic disturbance.

(2) The patient will be hospitalized no more than 48 hours. When DD Form 2770 is used for these cases, the physical examination section must fully describe the cardiopulmonary findings. (Terms such a "normal," "wnl," and "negative" will not be used.) The physical examination section must also describe any exceptions or other pertinent findings.

d. DD Form 2770 will never be used for American Society of Anesthesiologists Class III patients, no matter what the length of stay.

e. When DD Form 2770 is used, SF 502 may be replaced by a final progress note (SF 509). However, when hospitalization exceeds 48 hours, SF 502 must be prepared. In such cases, SF 504, SF 505, and SF 506 need not be completed in addition to DD Form 2770; the reasons for the extended stay will be fully recorded in the progress notes (SF 509). Conversely, when a long stay is expected but the patient is discharged within 48 hours, DD Form 2770 will

not be prepared in addition to the already completed SF 504, SF 505, and SF 506, and the case may be summarized in the progress notes (SF 509) instead of in SF 502.

9–22. DA Form 4359

Consent for admission of patients to psychiatric treatment units will be recorded on DA Form 4359 (Authorization for Psychiatric Service Treatment). This form is available on the Army Electronic Library (AEL) CD–ROM and the USAPA Web site, www.usapa.army.mil.

9–23. DD Form 792

DD Form 792 (Twenty-Four Hour Patient Intake and Output Worksheet) is a worksheet used to record all fluid intake and output. It is completed by nursing personnel. After the totals have been recorded on the graphic records (DD Form 2770 or SF 511 (Medical Record-Vital Signs Record)), the worksheets should be destroyed. The worksheet should not be filed in the ITR.

9–24. DA Form 3950

DA Form 3950 (Flowsheet For Vital Signs and Other Parameters) is a worksheet or a flowsheet to record temperature, pulse, blood pressure, and respiration; or the columns may be labeled as needed. Vital signs for a group of patients can be recorded and subsequently transcribed to the graphic record (SF 511) of the individual patient. The worksheet may be destroyed after the readings have been transcribed to the individual patient's graphic record. When used as a flowsheet to record frequent vital signs or other parameters for an individual patient, the DA Form 3950 will be filed in the patient's ITR.

9–25. Laboratory test requisition and reporting forms

.a. Laboratory test requisition and reporting forms (SF 545, SF 546, SF 547, SF 548, SF 549, SF 550, SF 551, SF 552, SF 553, SF 554, SF 555, and SF 557) and automated versions of these forms are used to request laboratory tests and to report the results of those tests. The forms are three-part sets (original and two copies). When a test is requested, the whole set is sent to the laboratory. After the results are recorded, the third copy is kept in the laboratory files. The original is routed for immediate filing in the ITR or OTR or outpatient HREC. The second copy is routed to the requesting practitioner for use and disposition. Carbon copies of laboratory reports will not be filed in the ITR, OTR, or outpatient HREC.

.b. Automated methods of reporting and requisitioning laboratory tests are authorized using CHCS and other approved hospital or laboratory information systems. When computerized or automated cumulative final reports are provided and filed in the medical record, the daily or weekly summary report for the period of time covered by the cumulative final report should be discarded.

.c. The MTF commander will ensure that each patient's laboratory test requisitions and reports are prepared correctly. General instructions for preparing these forms are given in table 9–2. Instructions for each form are given in table 9–3.

.d. Health-care practitioners should refrain from making hand-written notations on the laboratory reports; such notes belong in the progress notes (SF 509). Results of provider-performed microscopy tests should also be noted on SF 509. When used for laboratory

reports, the laboratory forms listed in *a*, above, are restricted for use by recognized organizational laboratories only. These forms will not be used to make extra copies of telephonic reports, to record waived or minimally complex laboratory testing performed by nursing personnel, or to record provider-performed microscopy.

.e. To meet the requirements of accrediting bodies and the DOD Clinical Laboratory Improvement Program, the laboratory must ensure that test requisitions include—

(1) The patient's name or other unique identifier;

.(2) The name of the authorized practitioner requesting the test, and if appropriate, the individual to contact to enable reporting of imminent life-threatening laboratory results;

.(3) The test(s) to be performed;

.(4) The date of specimen collection; and

.(5) Any additional clinical information relevant and necessary to a specific test request to ensure accurate and timely testing and reporting of results.

.f. To meet the requirements of accrediting bodies and the DOD Clinical Laboratory Improvement Program, the laboratory must ensure that test reports are sent promptly to the test requester, that the original report or an exact duplicate (paper or electronic copy) of each test report, including final and preliminary reports, are retained by the testing laboratory for a period of at least 2 years after the date of reporting. (Immunohematology reports under 21 CFR 606, Subpart I, and 42 CFR 493.1107 and 1109, must be retained for at least 5 years after records have been completed, or 6 months after the latest expiration date for the individual product, whichever is later; pathology reports must be retained for a minimum of 10 years. See TM 8–227–3/NAVMED P–5101/AFMAN(I) 41–119, for records requirements pertaining to the testing of blood and blood components.) The laboratory test report must indicate—

.(1) The name and address of the laboratory location at which the test(s) was performed;

.(2) The test(s) performed;

.(3) The test result(s); and, if applicable, the units of measurement; and

(4) Pertinent reference ranges, as determined by the laboratory performing the test, either on the report form or available in the patient's medical record.

9–26. DA Form 4256

.a. Use of DA Form 4256. DA Form 4256 is a three-copy, carbonless form. The original copy (white) remains with the patient's permanent record. The second copy (pink) is sent to the pharmacy, where it is kept until the patient is discharged. (The pharmacy must receive a copy of all orders to ensure appropriate surveillance of food-drug and laboratory-drug interactions.) The ward copy (yellow) may be used as a medication or treatment reminder and will be discarded when no longer needed. Instructions for completing DA Form 4256 are provided in *b* through *g*, below.

.b. Preparation. All entries will be made with ball-point pen using blue-black or black ink, or they will be computer entries. Entries must be legible on all three copies. In each Patient Identification section, addressograph plates should be used. (See paras 3–5*b* and 3–6.) The Nursing Unit, Room Number, and Bed Number blocks should also be

completed.

.c. Method of writing orders. More than one order may be written in each section of DA Form 4256, but no more than one order may be written on a single line. The prescriber will record the date, the time, and sign each entry. Standard orders overprinted on DA Form 4256 also must include the date, the time, and the signature of the prescriber.

.d. Method of accounting for orders. Actions taken to comply with written orders will be noted in the far right column of DA Form 4256, the "List Time Order Noted and Sign" column.

.(1) The clerk or nurse who notes two or more orders may enclose the orders in brackets, list the time orders are noted, and sign or initial his or her name. All STAT orders, however, must be individually accounted for with the time the order is noted and the signature or initials of the clerk or nurse. This entry implies that proper action has been taken or the order, as written, has been transcribed on DA Form 4677 or DA Form 4678.

.(2) Single action orders need not be transcribed to the DA Form 4677 or DA Form 4678 if the order is carried out by the RN. A single action order is a one-time order that is completed within the verifying nurse's tour of duty. It should require no further nursing activity once signed off. Documentation of the efficacy of the intervention, as appropriate, is required. In the right-hand column of the form, the RN will write "Done," with his or her signature and the date and time that the order was completed. Each single action order must be accounted for individually; brackets will not be used to sign off a group of single action or "STAT" orders. If the single action is not completed within the responsible RN's tour of duty, the order will be transcribed to the DA Form 4677 or DA Form 4678.

.e. Method of discontinuing orders. To discontinue a medication or treatment, the prescriber must write and sign the stop order. (Automatic stop orders (for example, for antibiotic or controlled drugs) will be governed by written local policy.) When an order is stopped, it must be accounted for (see *d*, above) and then noted on DA Form 4677 or DA Form 4678 by putting "discontinued/date/initials" and drawing a single line through the HR (hour) and Date Com-pleted/Dispensed blocks beside the stopped order. Corresponding annotations in an automated system such as CHCS are acceptable.

.f. Verbal orders. Verbal orders will be used only for emergency STAT orders. The RN who accepts the order must write it on DA Form 4256 and enter after it "Verbal order (doctor's/nurse's name, rank, Army Nurse Corps, or RN)." The prescriber must countersign the order as soon as possible, but no later than 24 hours after the emergency.

.g. Telephone orders. Telephone orders will be held to the minimum and accepted only by an RN; they must be countersigned by the prescriber within 24 hours. The RN accepting the order(s) must record the order(s) on the DA Form 4256 followed by the notation "Telephone Order(s)"; the physician's name; and the RN's name, rank, and title. If the prescribing physician is unable to countersign the telephone order, he or she may contact the covering physician and discuss the order. The covering physician may then countersign the telephone order for the prescribing physician.

9–27. DA Form 4677

a. Purpose. DA Form 4677, printed on green paper, is used for non-medication doctors'

and nurses' orders and to document the patient's acuity category. Medical orders will be transcribed from DA Form 4256. Nursing orders will be indicated by writing "NIO" for nursing initiated order, and the RN's initials are noted in the Initials column. Nursing orders may relate to identified nursing problems and or nursing diagnoses, or reflect established standards of care. Nursing orders that reflect standards of care may be written without a corresponding problem. Overprints of orders may be printed on the form in accordance with appropriate local or command policy.

.b. Preparation. Enter all patient identification data as indicated on the form.

.c. Content.

(1) Allergies. Specify the presence or absence of allergies. When known, indicate the specific allergen.

(2) Primary medical diagnosis. Enter the current diagnosis. Add other diagnoses if they significantly affect care to be given.

(3) Recurring actions.

(a) Order date. Enter the date that the current order was written.

.(b) Initialing. The clerk or nurse who transcribes an order must initial the appropriate block on the form. If a ward clerk or an LPN transcribes the order, an RN must initial in the lower portion of the box. The RN's initials indicate that the RN verified the transcribed order with the original order on DA Form 4256 and is, therefore, accountable for its accurate transcription and its appropriateness from a nursing standpoint.

.(c) Recurring actions, frequency, time. This section is used for actions that are scheduled and repetitive. The complete order, as originally written, must be transcribed to this section.

1. Hour. Specific times for the order to be accomplished are listed vertically. Each space is for a separate time of action. Orders that are in effect throughout the shift and are not time-related (for example, seizure precautions, intake and output) are indicated by designating the inclusive times for each shift; for example, 07–15, 15–23, 23–07. The abbreviations D, E, and N will not be used.

2. Date. The top row of spaces is used to indicate the date the action is accomplished.

2. *3.* Initialing. The person responsible for carrying out the order or for verifying completion will initial the block opposite the specific hour for action and under the appropriate date column.

3. *4.* Use of DA Form 4677 to document patient acuity. The Workload Management System for Nursing (WMSN) acuity category is documented on this form. An entry should be made in the Recurring Actions/Frequency/Time column: "WMSN Category." Two lines are used. The patient's WMSN acuity category is recorded on the first line under the appropriate date, and the initials of the RN who determined the acuity category are recorded in the block directly beneath the category.

4. *5.* Use of DA Form 4677 as a flowsheet. To reduce the writing of narrative notes, DA Form 4677 can be used to document patient information requiring frequent recording and or the patient's response to medical orders and nursing interventions. All assessment or measurement components must be specified in the order written on DA Form 4677, for example, check pedal pulses and right leg circumference every 4 hours. The findings

related to this assessment are likewise recorded on DA Form 4677. A local policy is required to explain this method of documentation and to code the patient's response to care. For example, initials only indicate that the order has been completed; initials and "+" indicate that the nursing intervention and or patient response was satisfactory and or within normal limits; initials and "O" indicate the results of the nursing intervention and or patient response were unsatisfactory, not observed or omitted. All negative or unexpected responses or unfavorable patient outcomes require documentation in nursing notes. Any codes used must be defined on the DA Form 4677.

5. *6.* Discontinued order. When a multiple line order is discontinued, draw a diagonal line across the unused blocks. For a single line order, draw a horizontal line; "discontinued/date/time/initials" will be written above the line drawn. For quick, visual recognition of a discontinued order, a yellow highlighter or accent pen which will not penetrate the paper or obliterate the writing may be used to line over the order and the associated blocks.

d. Single Actions. If a single action order is not completed within the responsible RN's tour of duty, the order becomes a delayed order and is transcribed to the Single Actions column.

.(1) Order Date. Same as in *c*(3)*(a)*, above.

.(2) Initialing. Same as in *c*(3)*(b)*, above.

.(3) Single Actions. The complete order, as originally written, must be transcribed to this column.

.(4) Date and Time to Be Done. If known, enter the date and time the action is to be taken. Indicate "on call" if so ordered.

.(5) Completed order. The Date/Time/Initial blocks show that the order was accomplished. If the order was not completed, do not initial. Place a circle(s) in the Date/Time/Initial block(s) and explain in the nursing notes.

.e. Pro re nata (PRN) actions. Use this when the time of an order is not predictable. Leave sufficient space on the DA Form 4677 to accommodate the expected frequency of the PRN action, and annotate the patient's response in accordance with local policy and the direction provided in *c*(3), above.

.(1) Order/Expir (expiration) Date. Enter the date the current order is written in the top portion. If applicable, enter the expiration date in the bottom portion.

.(2) Initialing. Same as in *c*(3)*(b)*, above.

.(3) PRN Action, Frequency. Indicate the action to be taken and its frequency.

.(4) Time/Date/Completed. Each block indicates a separate action. The person completing the action enters the date, time, and initials at the time of completion.

.f. Recopied orders.

.(1) When space in the Date Completed column is filled, a double line is drawn across the entire page just below the last entry. Directly below the double line, or on a blank DA Form 4677, write "Recopied Orders." The upcoming dates are filled in, for each order still in effect, and the date of the original order is recopied. The individual copying the order, if other than an RN, and the verifying RN will follow the initialing procedures as previously described in c(3)(b) above. If the RN recopies the orders, the only required authentication will be the nurse's signature at the end of the recopied orders.

(2) In the event that orders need to be recopied before the Date Completed columns are filled, the order is indicated as recopied by a diagonal or single line drawn across the remaining blocks. Recopied/date/initials are noted above the line. Existing initials are bracketed to indicate no further use of the remaining blocks.

9–28. DA Form 4678

a. Purpose. DA Form 4678, printed on white paper, is for medication orders and accompanying nursing orders that pertain to the administration of the ordered medication. (See figure 9–1.) Medication orders will be transcribed from DA Form 4256. Nursing orders pertinent to medication administration, initiated by the RN, and written on this form, will be indicated by placing NIO/nurse's initials in the Verify By Initialing column. Overprints of physician or nurse orders may be printed on the form in accordance with appropriate command or local policy.

.*b.* Preparation. Enter all patient identification data as indicated on the form.

.*c.* Content.

(1) Allergies. Specify the presence or absence of allergies. Indicate specific allergies.

(2) Primary diagnosis. Enter current diagnosis. Add other diagnoses that significantly affect patient care requirements.

.(3) Recurring medications.

.*(a)* Order date. Enter the date of the current order.

.*(b)* Initialing (transcribed order). The clerk or nurse who transcribes an order must initial the appropriate block on the form. If a ward clerk or an LPN transcribes the order, an RN must initial in the lower portion of the box. The RN's initials indicate that the RN verified the transcribed order with the original order on DA Form 4256 and is, therefore, accountable for its accurate transcription and its appropriateness from a nursing standpoint.

.*(c)* Recurring Medications, Dose, Frequency. This column is used for recurring drug administration, including controlled substances, or actions when compliance with the order is repetitive and scheduled. The complete order, as originally written, must be transcribed to this section.

.*(d)* Hour. Specific times for the order to be accomplished are listed vertically. Each space is for a separate time of administration. Orders that are continuous throughout the shift and are not time-related (for example, intravenous (IV) rates, oxygen administration) are indicated by designating the inclusive times for each shift; for example, 07–15, 15–23, and 23–07. The abbreviations D, E, and N will not be used.

(e) Date. The top row of spaces is used to indicate the date the action is accomplished or medication is administered.

.*(f)* Initialing (medication administration). The nurse will initial the block opposite the specified time for administration and under the appropriate date column. The patient's response to the medication may also be indicated. When placed in the designated block, the nurse's initials indicate that the medication has been administered. The nurse's initials with the letter "(E)" indicate that the administered medication was effective and achieved

the desired results (for example, meperidine given for pain relieved the pain). The nurse's initials with "(I)" indicate that the administered medication was ineffective. This notation requires a nursing note to describe the patient's status and the actions taken to address the patient's condition.

.(g) Discontinued order. When a multiple line order is discontinued, draw a diagonal line across the unused blocks. For a single line order, draw a horizontal line; "discontinued/date/time/initials" will be written above the lines drawn. For quick, visual recognition of a discontinued order, a yellow highlighter or accent pen, which will not penetrate the paper or obliterate the writing, may be used to line over the order and the associated blocks.

.d. Single order action, pre-operatives. A single action medication order that is not completed within the verifying RN's tour of duty becomes a delayed order and is transcribed to the single order, pre-operatives column.

.(1) Order date. Self-explanatory.

.(2) Initialing. Same as in *c*(3)*(b)*, above.

.(3) Single Order, Pre-operative. The complete order, as originally written, must be transcribed to this column.

.(4) Date/Time To Be Given. If known, enter the date and time the drug is to be administered. Note "on call" if so ordered.

.(5) Completed order. The nurse who administers the medication enters the date, time, and his or her initials. Do not initial an order that is not implemented. Place a circle(s) in the Date/Time/Initials block(s) and specify the reason in the nursing notes.

.e. PRN medications. Use when the time of administration is not predictable.

.(1) Order/Expir Date. Enter the date the current order is written in the top portion. If applicable, enter the expiration date in the bottom portion.

.(2) Initialing. Same as *c*(3)*(b)*, above.

.(3) PRN Medication, Dose, Frequency. Indicate the medication to be administered, dose, route, frequency, andreason for the medication (for example, benadryl 25 mg, po at bed time, prn, sleep). The patient response may be documented as described in *c*(3)*(f)*, above, in the nursing notes.

.(4) Time/Date Dispensed. Each block indicates a separate action. The person administering the medication enters the time, date, and initials at the time of completion.

.f. Recopied orders. When space in the Date Dispensed column is filled, a double line is drawn across the entire page just below the last entry. Directly below the double line, or on a blank DA Form 4678, write "Recopied Orders." The upcoming dates are filled in for each order still in effect and the date the original order is recopied. Initialing procedures are described in *c*(3)*(b)*, above. If the RN recopies the orders, the only required authentication will be the nurse's signature at the end of the recopied orders.

.g. DA Form 4028 (Prescribed Medication). When unit dose is not provided, DA Form 4028 will be prepared whenever a medication is prescribed. The purpose is to ensure that patients receive medications as prescribed. The card will be destroyed upon change of orders. This card is not used when unit dose pharmacy support is provided.

9–29. DA Form 4107

.a. General. The medical or dental officer responsible for the patient's operation or

special treatment will initiate and complete section A, DA Form 4107 (Operation Request and Worksheet), except for items 20 and 21. Section B will be completed by the anesthesia provider and or the circulating RN. The anesthesia provider will complete items 32–39; the circulating RN will complete items 40–42 and 45–47. All other items can be completed by either the anesthesia provider or the circulating RN. DA Form 7001 (Operating Room Schedule) and DA Form 4108 (Register of Operations) are based on accuracy and completeness of DA Form 4107.

.b. Purpose. This form is intended for concurrent and sequential use to schedule and record all surgical procedures performed in the main ORs and ambulatory surgery center. When anesthesia and or OR nursing personnel are required to attend or monitor patients, DA Form 4107 will be used (for example, labor and delivery, special procedures x-ray clinic, cardiac catheterization).

c. Detailed instructions.

.(1) Section A–Request for Surgery.

.(a) Items 1 through 14. Self-explanatory.

.(b) Item 15. Apply the National Research Council Criteria for Wound Classification.

.(c) Item 16. Self-explanatory.

.(d) Item 17. Self-explanatory.

.(e) Item 18. Self-explanatory.

.(f) Item 19. Note special instructions, to include special solutions for prepping.

.(g) Item 20. Chief, operating room nursing section or designee will note name(s) of scrub person(s) followed by name(s) of circulator(s).

.(h) Item 21. The chief of anesthesia and operative service or designee will complete.

.(i) Item 22. Indicate type of anesthesia desired (for example, general, regional, local, or topical).

.(j) Item 23. Indicate special instruments and or equipment other than routine (for example, power equipment, tray, tourniquet, etc.). In addition, indicate patient limitations (for example, deaf, mute, language barrier), which will assist operating room staff in planning patient care.

.(k) Item 24. Self-explanatory.

.(2) Section B–Operation Worksheet.

.(a) Items 25 and 26. Self-explanatory.

.(b) Item 27. “Septic” is defined by using classification of the operative wound, and applying the National Research Council criteria: Clean wounds, clean-contaminated wounds, contaminated wounds, and dirty-infected wounds.

.(c) Items 28–32. Self-explanatory.

.(d) Item 33. Anesthesia Time: "Time Began" is defined as the beginning of patient preparation after the patient has arrived in the holding area of the surgical suite or satellite facility. This time commences with chart review and placement of IV lines, invasive monitors, and or noninvasive procedures by anesthesia personnel. "Time Ended" means actual clock time at which the anesthesia provider leaves the patient in the post anesthesia recovery unit, intensive care unit, or other post surgical unit.

.(e) Items 34–38. Enter agents and techniques. If none, indicate by lining out the appropriate space(s).

.(f) Item 39. Note adjunctive procedures not intrinsically a part of delivery or routine anesthesia such as hypothermia, anesthesia by tracheostomy, central venous pressure monitoring, Swan-Ganz monitoring, transvenous pacemakers, and arterial lines.

.(g) Item 40. "Time Began" means the actual clock time the nursing team began preparation in the room assigned for the case. "Time Ended" means actual clock time the cleaning of the room is completed and ready to receive the next patient. Note, these times will not be the same as anesthesia or operation times.

.(h) Items 41–44. Self-explanatory.

.(i) Item 45. Note number(s) and type(s) of drain(s).

.(j) Item 46. Indicate "None," "Correct," or "Incorrect." Enter the last name of the professional nurse who performed and verified the sponge count.

.(k) Item 47. Identify the specimen and disposition (if other than pathology).

.(l) Item 48. Clearly state the operative diagnosis. (Do not use "same as item 7.")

(m) Item 49. Clearly state the entire operation performed. (Do not use "same as item 9.") Indicate the total number of episodes by using the following definitions.

1. *1.* Episode of OR Nursing. An episode of OR nursing is based on a combination of two factors: OR personnel and time. One episode of OR nursing is assigned for the initial 3 hours or fraction thereof, for one nursing team. An OR nursing team consists of one scrub person and one circulator person. OR nursing personnel are permanently assigned to the OR. Each additional OR nursing person for a particular case equals 0.5 episode. The additional OR nursing person does not include an individual providing break and or lunch relief.
2. *2.* Episode of Anesthesia. An episode of anesthesia is also based on a combination of two factors: anesthesia personnel and time. One episode of anesthesia is counted for the initial 3 hours or fraction thereof for one anesthesia provider. Any fraction over the initial 3-hour period is an additional episode. One episode is also added for each additional anesthesia provider fully assigned to the case.
3. *3.* Method of Calculation. The case scenarios shown in figure 9–2 provide examples for calculation of episodes of OR nursing and episodes of anesthesia.

(n) Item 50. Enter any complications that occurred in the OR or those unusual situations in the preoperative period that relate to the anesthesia or surgical experience.

(o) Item 51. When a dictation capability exists, the physician will sign after completion of dictation.

.(p) Recorded in Register. After the case has been recorded on the DA Form 4108 or entered into the automated data processing system, the person initiating this task will indicate completion by initialing.

.d. Disposition. The form consists of four copies. Upon completion of section B, DA Form 4107 is separated. Retain the original copy in the OR section until the information is transcribed to DA Form 4108 and SF 516. Distribution of additional copies will be determined by the chief, anesthesiology and operative service. All copies may be destroyed when no longer needed as deemed appropriate according to local policy.

9–30. DA Form 7001

.a. General. DA Form 7001 is prepared daily for the next day reflecting all scheduled

operative and anesthesia procedures, additional procedures, such as emergencies, and changes to the OR schedule. Incorporating elements from section A of DA Form 4107, prepare DA Form 7001 either on the cutsheet version or on offset masters for printing of duplicate copies.

.b. Preparation and distribution. Entries may be typed or handwritten, if they are legible. Additionally, DA Form 7001 can be prepared electronically and may be duplicated for distribution. It serves as a central communication tool concerning surgery. DA Form 7001 covers a 24-hour period beginning at 0000 and ending at 2400. Cases beginning on one day and ending on the next day should be posted on the beginning day's schedule. (For example, the case started at 2300, 24 Sep 96 and ended at 0200, 25 Sep 96. The case should be recorded on the schedule for 24 Sep 96.)

.c. Use. The original DA Form 7001 can be used to verify data recorded on DA Form 4107 prior to entry onto DA Form 4108. Duplicated DA Form 7001 can be used for patient transport identification slips, individual operating room case slips, centralized materiel service instrumentation verification, performance tracking and trending, pre- and postoperative statistical data, anesthesia interview assignments, progression of operative schedule, completion and or cancellation of cases, mass casualty exercises, staffing of personnel, and any other pertinent patient information (for example, isolation precautions, special care needs for transport).

d. Detailed instructions.

.(1) Item 1. Enter the name of the MTF.

.(2) Item 2. Self-explanatory.

.(3) Item 3. Enter the time the case is scheduled to begin and in what specific (number) OR; for example, 0730, OR #1.

(4) Item 4. Enter the patient's full name, identification category, age, and religion; for example, Williams, John D., AD, 18, P.

(5) Item 5. Self-explanatory.

.(6) Item 6. Enter ward from which the patient is sent to surgery and the ward or specialty care unit to which the patient will go after surgery (for example, from 64 to RR).

.(7) Item 7. Enter the proposed surgery as recorded on DA Form 4107, item 9 (for example, exploratory laparotomy, possible bowel resection).

.(8) Item 8. Enter the names of all operating surgeons with the primary surgeon first (for example, Dr. White and Dr. Smith).

.(9) Item 9. Enter the name and status of the OR nursing personnel scrubbing and circulating. Indicate scrub with (S) and circulator with (C) (for example, SGT Tamp (S) and CPT Rowe (C)).

.(10) Item 10. Enter the names of all the anesthesia providers to include physician staff personnel (for example, Major Down, MC or Dr. Jones).

.(11) Item 11. Enter the anesthetic as indicated on DA Form 4107, item 22. Enter blood and associated products as indicated on DA Form 4107, item 14 (for example, General/WB 2000 cubic centimeters FFP 1500 cubic centimeters).

e. Disposition. Destroy upon completion of entry of data onto DA Form 4108, or when

no longer needed as deemed by local policy.

9–31. DD Form 1924

DD Form 1924 (Surgical Checklist) will be placed on the front of each patient's chart prior to surgery. It provides a visual check of the medical forms and procedures required prior to arrival in the operating suite. The DD Form 1924 is designed to permit use of the addressograph to complete the patient's identification. Nursing personnel will place their initials in the proper columns as each preoperative check and procedure is completed. The RN releasing the patient to the OR staff members will sign this form at the time of release. The form will be destroyed when no longer required.

9–32. DA Form 4108

a. General. DA Form 4108 is a record of all surgical procedures performed. Normally, it will be kept and maintained in the OR suite. Where surgical procedures or anesthesia monitoring is undertaken outside the OR suite (for example, obstetrical suite, urology, cardiology, plastic, dental clinic, and so forth), an individual DA Form 4108 will be maintained by the respective department, service, or clinic. Information from the completed DA Form 4107 will be transposed to DA Form 4108. Accuracy and completeness of the register is imperative since this document may be used for statistical computations, research, feeder reports to higher headquarters, and hospital accreditation, as well as support for staffing and space requirements.

b. Availability. Covers for the chronological collection of each year's DA Forms 4108 are available through supply channels.

c. Arrangement. Arrange pages chronologically with monthly recapitulation of total procedures. Sequence number 1 is the first procedure begun from 0001 on the first day of the month. The final sequence number for the month is the last procedure begun before 2400 on the last day of that month. Pages will be numbered in the space provided in the upper right corner. Both sides will be used. At the end of each month, tally figures may be entered in the margin, and the cumulative total carried to the upper left corner of a new page to begin a new month's record. Suitable tabs may be affixed to identify the month.

d. Recording data. Entries may be typed or handwritten if they are legible. Entries are adaptable for computer input.

e. Correcting errors. Erasures are prohibited. A line will be drawn through an incorrect entry. Initials of the person making the entry will be placed above the lined portion. Correct information will be recorded following the lined entry.

f. Detailed instructions.

(1) Hospital. Enter the name and location.

(2) OR number. Enter #1, #2, #3, etc.

(3) Emergency. Indicate with an "X" if an emergency procedure is used.

(4) Case number. Sequence within the particular OR number noted in (2) above.

(5) Surgeon(s). The surgeon is listed first, followed by the assistants in descending order.

(6) Combat. Use currently acceptable medical letter combination or abbreviation to indicate the source of injury if the result of hostile fire.

(7) Nursing time. Indicate time "Began" and time "Ended" from DA Form 4107.

.(8) Counts. Indicate after each (for example, sponge, needle or sharp, instrument) "C" for correct, "IC" for incorrect, or none.

.g. Disposition. These binders will be disposed of under AR 25–400–2. Maintain at least from one JCAHO visit to the next. Additionally, maintain as deemed by local policy.

9–33. DA Form 5179

.a. General. DA Form 5179 (Medical Record-Preoperative/ Postoperative Nursing Document) consists of a nursing assessment and generalized plan of care for patients undergoing an operative procedure, and a postoperative evaluation. This form is to be prepared by an RN and will be a permanent part of the patient's clinical record. Data collection and review of the plan of care is to be accomplished with the patient prior to the operative procedure. If unable to obtain data; for example, in emergency surgery, document this in item 5. Item 11 is to be completed within 24 hours of the operative procedure.

.b. Purpose. This form provides a record of the continuation of the nursing process from the time the patient leaves the ward or unit to go to the OR until the patient returns to a receiving unit.

c. Detailed instructions.

(1) Items 1–4. Self-explanatory.

.(2) Item 5. Provides space for additional information such as family requests, information not identified in items 6 to 8 of the form.

.(3) Item 6. Lists potential problems and or needs of the patient. If the stated problem is relevant to the patient, an "X" should be placed in the area provided at the beginning of each statement and the problem statement completed by filling in each blank. A space is provided to write additional problems and or needs.

.(4) Item 7. States expected goals and outcomes. A space is provided to write additional goals and outcomes, if necessary.

.(5) Item 8. Lists OR nursing interventions. The interventions not applicable to the patient are to be lined out and initialed. Space is provided for documenting additional interventions.

.(6) Item 9. Self-explanatory.

.(7) Item 10. Signature of RN completing Item 8.

.(8) Item 11. Must be completed within 24 hours after completion of the operative procedure. Each patient problem and or need identified in Item 6 must be evaluated here.

(9) Items 12–13. Self-explanatory.

9–34. DA Form 5179–1

a. General. DA Form 5179–1 (Medical Record-Intraoperative Document) documents the care of each patient undergoing an operative procedure. The form is to be initiated

prior to the operative procedure and completed after the operation. The form is to be prepared by an RN and will be filed on the right side of the ITR (DA Form 3444-series).

b. Detailed instructions.

(1) Item 1. Record how the patient arrived; that is, via litter, wheelchair, or bed; and by whom transported.

.(2) Item 2. Verify, by RN, with payroll signature with rank and corps or civilian grade; for example, Mary S. Smith, CPT, AN or Betty T. Jones, RN, GS–10.

.(3) Item 3. Specify day, month, year; use the military time the patient entered the main operating suite door.

.(4) Item 4. Record the time the patient enters the OR and specify OR number plus case number for that room (for example, OR #l case 1).

.(5) Item 5. Check descriptive word that best describes patient’s preoperative status and any other appropriate comments.

.(6) Item 6. Record names and titles of assigned personnel (permanent staff) and others, such as student personnel, relief (meals, changes of shift) personnel.

.(7) Item 7. Specify intraoperative position of the patient; record any other position(s) (for example, split leg) and all positional devices or aids under comments. Draw or annotate any device or aid and its placement in Item 9.

.(8) Item 8. Indicate the hair removal method in the appropriate box with "X" if hair removal is done by ORpersonnel; record the name of the individual performing procedure. Record type of site preparation solution and its strength (for example, 1 percent, 2 percent); site of preparation, and who performed preparation. Insert any appropriate comments such as skin conditions or reactions, for either task.

.(9) Item 9. Record placement of indicated items by appropriate legend. Record other external devices such as blood pressure cuff, electrocardiogram electrodes or any other devices that are required by local facility policy or standing operating procedure.

.(10) Item 10. Check YES (done) or NO (not done) for each count listed. Record each count as correct "C" or incorrect "IC"; if incorrect make an explanatory entry in section 19. If "Other" is YES, add type of count and body space or cavity; for example, urinary bladder. Signature of the circulating RN responsible for the count is made across the three lines or on each individual line. Print the name of the scrub person that performed the count with the circulating RN.

.(11) Item 11. Self-explanatory.

.(12) Item 12. Record if electrosurgical unit (ESU) was used by placing an "X" in the YES or NO block. Enter medical maintenance control number for every ESU and bipolar unit used and any other information required by local facility policy (for example, manufacturer and model number). Record grounding pad(s) used (brand and lot number) and any other information required; that is, name of individual applying or removing pad.

.(13) Item 13. List prosthesis or implant (for example, bone, screws, plates, vascular grafts, hulka clips, and so forth) with manufacturer and identification numbers (lot number, quality control number) if available; attach sticker labels from implants if available.

.(14) Item 14. Record any medications that the patient receives in the operating room not given by anesthesia personnel. Note wound irrigations as follows: NSS=normal saline solution; BSS=balanced salt solution; method of irrigation (for example, pulse, asepto, lavage), and when indicated; for example, for pediatric patients, note amount.

Medications and orders are to be signed by the physician as the same verbal orders on DA Form 4256. Other orders or treatments are those performed during the operative procedures; for example, catheterization.

.(15) Item 15. Record x rays and sites as indicated; specify special techniques (for example, fluoroscopy), and or equipment, (for example, C arm).

.(16) Item 16. Enter "X" in the YES or NO blocks for specimens sent to the laboratory. Identify in NAME spaces the specimens sent to the laboratory by type and source or tissue; use FS for frozen section and C for culture. Examples: FS, nodule left vocal cord; C, anaerobic, gallbladder. If there are more than 11 specimens, record them in item 19.

.(17) Item 17. Identify tubes, drains, and packings used by type, size, and site; for example, "vaseline gauze, 1/4 inch, L nostril."

(18) Item 18. Record any immobilizers used, type(s) of dressing applied and location(s). Examples: Posterior splint cast, Telfa, xeroform, dry sponge, and so forth. (Also see item 17.)

.(19) Use this section for further documentation or for reporting additional information on other items.

.(20) Item 20, 21. Self-explanatory.

.(21) Item 22. Signed by the RN with payroll signature with rank and corps or civilian grade.

.c. This form is adaptable for computer inputs.

9–35. SF 511

a. Preparation. Enter the patient’s identification data here and in the space at the bottom of the form.

b. Recording data. Number the "Hospital Day" line of blocks consecutively starting with the day of admission as 1. Use the post-day line as applicable. The day of surgery is the operative day and the day following surgery is the first post-operative day. Label the day and hour blocks. Graph the temperature by the use of dots (.) placed between the columns and rows of dots joined by straight lines. If the temperature is other than oral, document this by (R) for rectal,
(A) for axillary, or (TM) for tympanic. Graph the pulse by use of a circle (O) connected by straight lines. Enter therespiration and blood pressure on the rows below the graphic portion of the form. Graph frequent blood pressure readings by entering an "X" between the columns and rows of dots, at points equivalent to systolic and diastolic levels. Connect the two with a vertical solid line. Use blank lines at the bottom of the sheet to record special data such as the 24-hour total of the patient’s intake and output.

9–36. SF 536

SF 536 (Clinical Record-Pediatric Nursing Notes) may be used for pediatric patients instead of the SF 510.

9–37. SF 519–B

.a. SF 519–B (Radiologic Consultation Request/Report) will be used to request and report results of radiologic examinations, except in instances where the request and or report results are generated/stored electronically by the hospital information system. SF 519–B is constructed in three-part sets (original and two copies). When an examination is requested, the whole set is sent to the radiology department. After the results are recorded, the third copy is kept in the radiology department files. (For disposition instructions, see AR 25–400–2, file number 40–66y, photograph and duplicate medical files, and table 3–1 of this regulation.) The original is routed for immediate filing in the ITR, OTR, or HREC. The second copy is routed to the requesting practitioner for use and disposition. Carbon copies of radiologic reports will not be filed in the medical record.

.b. Whether a typewritten, automated, handwritten, or verbal report, the results of all "wet" readings must be documented in the patient's medical record. This documentation can be found on SF 519–B, SF 600, or SF 558.

9–38. DA Form 5009

DA Form 5009 (Medical Record-Release Against Medical Advice) will be used when the patient leaves the MTF against the advice of hospital authorities and attending practitioners. A parent or legal guardian will complete the "statement of representative" portion of the form if the patient is a minor or mentally incompetent. This form is available on the Army Electronic Library (AEL) CD–ROM and the USAPA Web site, www.usapa.army.mil.

Table 9–1 NATO national military medical authorities

Country	Address
Belgium	Etat-Major Du Service Medical Section Techniques Medicales Quartier Reine Elisabeth Rue d'Evere B-1140 Brussels, Belgium
Canada	National Defence HQ KIA OK2 Attention: Chief, Medical Services Ottawa, Ontario Canada

Table 9–1 NATO national military medical authorities—Continued

Country	Address
Denmark	Danish Armed Forces Health Services Jaegersborg Kaserne PO Box 96 DK-2820 Gentofte, Denmark
France	Direction Centrale du Service de Sante Armees Hotel des Invalides F-75997 Paris, France
Federal Republic of Germany	Institut fur Wehrmedizinalstatistik und Berichtswesen BergstraBe 38 D-53424 REMAGEN, Germany
Greece	Hellenic Army General Staff Medical Corps Directorate Stratopedon Papagou Holargos—Athens, Greece
Italy	Minestera della Difesa Direzione Generale Della Sanita' Militare Via S. Stefano Rotondo, 4 00184 Roma, Italy
Luxembourg	Luxembourg Army HQ Post Box 1873 L-1018, Luxembourg

Netherlands Inspectie Geneeskundige Dienst Koninklijke Landmacht Postbus 90824 2509 LV Den Haag, The Netherlands
Norway Joint Norwegian Medical Service Oslo mil/Huseby N 0016 Oslo, Norway
Portugal Ministerio Da Defesa Nacional Direccao-Geral de Pessoal Divisao de Saude Militar AV. Ilha dea Madeira, l, 4o 1400 Lisboa, Portugal
Spain Excmo. Sr General Director De La Disan Cuartel General Del Ejercito C/ Prim No 4 28014 Madrid, Spain

Turkey Genelkurmay Baskanligi Saglik Daire Baskanligi Ankara, Turkey

Table 9–1 NATO national military medical authorities—Continued

Country	Address
United Kingdom	Ministry of Defence Directorate of Medical Operations and Plans JHQ 224 Northwood, Middlesex HA6 3HP England
United States	
a. Army	Commander U.S. Army Medical Command ATTN: MCHO-CL Fort Sam Houston, TX 78234-6000
b. Air Force	Surgeon, U.S. Air Forces in Europe Ramstein Air Base Ramstein, Germany
c. Navy	Naval Military Personnel Command ATTN: NMPC-036 Navy Worldwide Locator Service Washington, DC 20370-5000

Table 9–2 General instructions for preparing laboratory forms

Block: Patient Identification.
Completed by: Clinic or ward.
Instructions: Enter patient's name, register number and FMP or SSN of inpatient (only FMP or SSN of outpatient), treating MTF, ward or clinic, and date test is requested.
Remarks: Enter this information correctly. If possible, enter it by mechanical imprinting, using the ward plate or patient's recording card. If not, use ballpoint pen or typewriter.

Block: Urgency.
Completed by: Clinic or ward.
Instructions: Check the proper box.
Remarks: This block is not on SF 553 or SF 554.

Block: Specimen/Lab. Rpt. No.

Completed by: Laboratory.
Instructions: Enter the specimen or laboratory report number.
Remarks: This entry may be used to identify and monitor the request form in the laboratory.

Block: Patient Status.
Completed by: Clinic or ward.
Instructions: Check the proper box.
Remarks: "NP" and "DOM" are not used by the Army.

Block: Specimen Source.
Completed by: Clinic or ward.
Instructions: Check the proper box or write in the needed information.
Remarks: Some forms request other specimen information:

.a. On SF 548, given specimen interval information.
.b. On SF 553 and SF 554, given infection information. Extra information is needed on these forms to identify sensitivities and infecting organisms. Enter this information in the Clinical Information and Antibacterial Therapy blocks.

Block: Requesting Physician's Signature.
Completed by: Clinic or ward.
Instructions: Enter clearly the name of the practitioner ordering the test. If he or she is a military member, enter grade and corps.
Remarks: The signature is not needed.

Table 9–2 General instructions for preparing laboratory forms—Continued
Block: Reported by.
Completed by: Laboratory.
Instructions: The technologist signs here after the test results have been verified.
Remarks: The chief of the laboratory ensures that test results are accurate.

Block: Date.
Completed by: Laboratory.
Instructions: Enter date that the report is completed by the laboratory.
Remarks: N/A

Block: Lab. ID No.
Completed by: Laboratory.
Instructions: Enter laboratory identification number.
Remarks: Like the Specimen/Lab. Rpt. No. block, this entry may be used to identify and monitor the request form.

Block: Remarks.

Completed by: Laboratory.
Instructions: Enter any special information for the practitioner or the patient’s records.
Remarks: N/A

Block: Specimen Taken.
Completed by: Laboratory, Clinic or ward.
Instructions: Enter date and time the specimen is taken.
Remarks: This block is completed by whoever takes the specimen, either laboratory or ward or clinic personnel.

Block: Tests Requested.
Completed by: Clinic or ward.
Instructions: Put an "X" beside the test that is needed. For tests not listed, write their names at the bottom of the list.
Remarks: On most forms, the correct box is marked "X."

Block: Results or Report.
Completed by: Laboratory.
Instructions: Write or stamp the results of each test performed.
Remarks: N/A

Table 9–3 Specific instructions for preparing laboratory forms

Form: SF 545 **Use:** To mount laboratory forms. **Remarks:** Instructions for mounting laboratory forms are printed on the bottom of SF 545. When a patient needs the same type of test several times, use the same display sheet for each test result form. When only a few tests are made, mount the forms on alternate strips (that is, 1, 3, 5, and 7). When there is a mixed assortment of forms, mount them in the most practical sequence. After mounting the forms, check the proper boxes in the lower right corner to show which forms are displayed.

Form: SF 546 **Use:** To request blood chemistry tests. **Remarks:** At the bottom of the list of tests, there is a block requesting a battery or profile of tests. When requesting this battery, enter the name of the profile.

Form: SF 547
Use: To request blood gas measurements, T3, T4, serum iron, iron-binding capacity, glucose tolerance, and other chemistry tests.
Remarks: N/A

Form: SF 548
Use: To request chemistry tests performed using urine specimens.
Remarks: Explain a check in the "Other" box under "Specimen Interval."

Form: SF 549
Use: To request routine hematology (including differential morphology), coagulation measurements, and other hematology tests.
Remarks: N/A

Table 9–3 Specific instructions for preparing laboratory forms—Continued

Form: SF 550
Use: To request urinalysis tests, both routine and microscopic.
Remarks: Use "HCG" to request and report measurements of human chorionic gonadotropin. Use "PSP" to request and report phenolsulfonphthalein measurements.

Form: SF 551
Use: To request tests that measure serum antibodies, including tests for syphilis.
Remarks: Definitions for the serology test abbreviations are as follows:
RPR-rapid plasma reagin card test for syphilis.
COLD AGG-cold agglutinins.
ASO-antistreptolysin 0 titers.
CRP-C-reactive protein.
FTA-ABS-fluorescent treponemal antibody-absorption test.
FEBRILE AGG-febrile agglutinins.
COMP FIX-complement fixation.
HAI-hemagglutination-inhibition.
TPHA-Treponema pallidum hemagglutination.
Write the name of the specific antibody determination in the COMP FIX or HAI block.

Form: SF 552
Use: To request tests for intestinal parasites, blood parasites such as malaria, and other tests performed using feces.
Remarks: N/A

Form: SF 553 **Use:** To request most bacterial identifications and antibiotic susceptibility testing. **Remarks:** See table 9-2 (Specimen Source block) for information on preparing the Infection, Clinical Information, and Antibacterial Therapy blocks.

Form: SF 554
Use: To request tests for fungi, acid-fast bacteria (tuberculosis), and viruses.
Remarks: See table 9-2 (Specimen Source block) for information on preparing the Infection, Clinical Information, and Antibacterial Therapy blocks.

Form: SF 555 **Use:** To request tests using spinal fluid. **Remarks:** To request bacteriological studies on spinal fluid specimens, also submit SF 553 or SF 554. When requesting electrophoresis measurements or other miscellaneous tests performed on spinal fluid, also submit SF 557.

Form: SF 557
Use: To request tests, such as electrophoresis and assays of coagulation factors, which are not ordered on other forms.
Remarks: N/A